**Notes for the presentation at the European Parliament 27th April on Medical Deserts and Rural Desertification**

My name is john Wynn-Jones, I work at 2 UK universities. I co-founded EURIPA (European Rural and Isolated Practitioners Association) in 1997 to provide a voice for those working in rural areas. ( <https://euripa.woncaeurope.org>) I chaired the Rural section of the World Organisation of Family Doctors for 6 years from 2013-2019

I am here to represent those health care professionals working in rural practice. I was a rural family doctor for over 35 years and probably the only one here with that level of personal experience.

Reading through all the projects, the majority of the outcomes and recommendations concentrate on policy and a top down approach. Success will also depend on a bottom up approach engaging with rural health professionals and rural communities. As a result of the diversity of rural communities a single top down approach will never work on its own.

I hear little about education & training and the role of academic institutions and professional bodies. We need to train and develop a workforce that is "Fit for Purpose" and ensure that all clinicians entering rural health care have the skills and knowledge to meet the unique challenges that they will face working on the periphery of care with confidence and positivity.

Finally, we must tackle what Professor Roger Strasser describes as the Geographical Narcissism that urban prejudice ensures that rural has always been second rate.

EURIPA is working to ensure that Europe develops a workforce that is fit for purpose and has developed a Blueprint for the future

Please Read the EURIPA Blueprint for Rural Practice (<https://euripa.woncaeurope.org/sites/euripa/files/documents/EURIPA%20Blueprint%20%20for%20Rural%20Practice%20.pdf>)

1. **The importance of listening to the workforce**

Statistics can be comforting to policy makers but so often they fail to illuminate the critical issues at hand (especially when you are dealing with low populations densities). EURIPA is in the process of gathering evidence of rural workforce initiatives and good practice throughout Europe as we speak. Rural communities are diverse and no future policy can be successful without the input of those providing the care. Policies will only be successful if Health Care Professionals (HCPs) choose to work in rural and isolated areas.

1. **Rural is different: The nature and needs of Rural Practice**

Rural is different and needs a special approach. One size does not fit all.

The focus for rural health care must be based on primary care where 90% of the interactions take place. Effective care must be delivered by multi-professional teams trained to meet rural needs.

National generic workforce training programmes do not meet the specific and complex needs of rural communities and the breadth of skills and knowledge needed

Its just not about having a workforce but it needs to be **fit for purpose and properly trained.** Rural practice needs to have academic status with academic challenges. Some evidence exists that the level of responsibility puts young clinicians off considering rural options. Providing care on the periphery will need a greater range of skills and knowledge. Rural needs to be a separate subspeciality and we need to see clinical schools, academic centres of rural health, researchers and teachers based in rural communities outside cities.

EURIPA has a developed a **Blueprint** for rural practice which we sincerely urge you to adopt.

We want to work with you.

Workforce policies must be rural proofed at an early stage in their development.

Rural clinicians must be generalists thus bucking the specialisation trends in urban healthcare.

1. **Evidence is limited**

Evidence so far in Europe is limited and sketchy but a number of innovative schemes are beginning to appear in the UK, Ireland, Scandinavia, France and the Czech Republic we must take heed of them. We must be honest with ourselves that we are only at the stage of describing examples of good practice rather than being able to provide concrete evidence.

\*Sound evidence however exists from other mainly rich countries such as Australia, North America, New Zealand and we can act on this evidence provided our actions are contextually sensitive

1. **What do we know that works**

We know so far that that the following innovations work globally:

* 1. Select rural students for your training programmes. Grow your own!
  2. Provide significant rural placements at undergraduate level
  3. Develop Rural Postgraduate Training programmes for those entering rural practice with ongoing, career long, training support
  4. Establish pathways to practice from University/college onwards
  5. Improving the status of rural practice: Move rural academic centres out of cities, develop higher degrees, make it a first choice and make health professionals proud to work in rural

Remember that rural clinicians have personal aspirations, family responsibilities, financial concerns and these needs must be addressed.

Working together is a Win Win for us all

Join us for our Rural Forum meeting in Romania 19th-21st October

In European countries most doctors have reported a significant increase in their workload since the start of the pandemic. Traditionally rural doctors work longer hours than their urban counterparts, managing the geographical challenges they face, the lack of support & resources, shortages within the workforce and managing a disproportionally elderly population. This excessive workload is reaching a stage where it is having a catastrophic impact on health care professionals with increasing stress, emotional distress and exhaustion. This has resulted in growing shortages and vacancies due to resignations, early retirement and ill health. As things stand, Medical Deserts are set to keep on expanding.

The COVID-19 pandemic has highlighted the need to protect the mental and physical health and well-being of healthcare workers, many of whom may be leaving their jobs earlier than expected.  
The literature shows that less experienced general practitioners, in smaller practices such as in rural areas and with more vulnerable patient populations are at greater risk of distress.  
The perception of having adequate government support is a significant protective factor for distress and this is what rural doctors expect from their governments.

**The Three Step Process to develop a Rural Health Care Workforce “Fit for Purpose”**

Three steps to developing a rural health workforce that retained, recruited, stable, fullfilled and is fit for purpose. Meeting these goals will need fundamental change and significant resources. This process will take time and as a result, I have considered a three step process. The European rural population is not insignificant, amounting to up to 1/3 of the total European population. When it comes to health care, they deserve better than they get now with Europe is facing increasing areas that are devoid health care services (Medical Deserts) Please view this plan alongside the EURIPA Blueprint for the Rural Workforce. (<https://euripa.woncaeurope.org/sites/euripa/files/documents/EURIPA%20Blueprint%20%20for%20Rural%20Practice%20.pdf>)

A transformative approach to rural health provision and the elimination of “Medical Deserts” across Europe can rejuvenate health care provision across the board, providing new models of health care which could also be applicable to urban areas as well, demonstrating the old adage “What works in urban will not always work in rural but what works in rural will always work in urban.

**What can we do now?**

* Invest in Primary Care. As over 90% of people accessing health services do so via primary care, it is crucial that this sector of health care is given the appropriate resources and support. Emphasis is so often placed on hospital services even though countries with the highest quality primary care have the best health outcomes. (Barbara Starfield)
* Address “Geographical Narcissism” where urban prejudices so often dominate research, educational interventions and health care provision. This refers to everything from where health care professionals are trained to later career choices, when so often the brightest and most successful students choose urban careers.
* Establish “Rural Health and Rural Healthcare” as a subspeciality in universities, professional bodies and policy circles.
* Grow your own: Choose students with a rural background. A rural school’s policy has been shown to boost recruitment and retention. School students may need support at school in earlier years, especially where local educational services are limited. The idea of choosing the brightest and the best may not lead to the best physicians and nurses in the future.
* **All** health care students should receive tuition/lectures on rural health and have at least one of their placements in a rural setting. Recent evidence suggests that even short placements can have a positive impact.
* Engage with local communities. They have much to offer and teach the students during their placements. Let the students understand the value of community.
* Identify those young doctors in training intending to enter rural practice and those training in rural regions. Provide them with extra training designed to meet the extended skills and knowledge that they will encounter in rural practice.
* Establish CPD provision for those professionals working in rural practice. Digital/virtual provision can ensure that all are able to benefit provided they are given protected time to participate.
* Ensure that all health care facilities have access to adequate broadband provision and access to telehealth services.
* Telehealth must be seen as a tool rather than a solution for the lack of rural services and “Medical Deserts”
* Ensure all rural health care professionals have the appropriate digital skills needed to communicate with patients, access information, data, manage telehealth services etc.
* Establish a network of rural tutors and preceptors in preparation for increased undergraduate and post graduate training provision. They must be paid appropriately for their contribution.
* Where HCP work single handedly or is small groups, provide locum payments to allow them to take time off for holidays and training courses
* Provide support, coaching and mentoring services in particular for young professionals and those in late careers.
* Consider the family needs of HCP and support them when possible.
* Opening up a dialogue across sectors and disciplines in academic, professional, sociological and policy sectors to coordinate rural health development with general rural development.
* A commitment to a robust rural proofing process for all health and social based policy that could impact on rural communities.
* Emphasis on competences rather than wholly based on qualifications when individuals provide health related services to patients.

**Later options**

* Enhance undergraduate curricula with more rural content such as rural examples in case based/problem based learning programmes.
* Provide extended longitudinal rural placements for undergraduate students lasting from 6-12 months. Europe appears to be behind in adopting these Longitudinal Integrated Placements although there is evidence that they are gradually being introduced in Europe.
* Establish Rural Postgraduate Training programmes, offering comprehensive primary care training including an extended range of skills and knowledge. Generic training for everyone is not an appropriate option for those entering rural practice. Extended skills could include emergency care, outdoor medicine, minor surgery, advanced mental health care, occupational health, public health etc….
* Make Masters and PhD programmes available to rural HCPs with the aim of building a body of rural knowledge, data, skills in the rural environment
* Establish funded rural research programmes to build up a body of rural evidence to counter the limited rural data available compared with urban health.
* Appointment of Professorial Chairs at Medical schools

**Longer term options**

The establishment of:

* Rural Health Research Centres based in rural areas (outside urban)
* Clinical medical/nursing schools based in rural areas.
* Rural Medical/Nursing schools.
* Begin to blur the boundaries between primary and secondary care with rural HCPs trained to deliver some of the services traditionally provided in secondary care hospitals. The Rural Generalist programme in Australia for Nurses and Doctors should be seen as an option provided that it is culturally and context sensitive.
* Be careful when you look at mandatory rural service for young doctors and nurses. They may temporarily fill places but too often they see rural with negativity and return back to urban when finished. Rural health care can be complex and in need of greater levels of skill and responsibility, yet we send our least experienced clinicians to deal with them

Other key words and ideas:

* Covid highlighted the problem which was already there. Medical deserts became more visible following the pandemic and its impact.
* Healthcare must be seen in combination with social care provision.
* Defining the problem doesn’t sort it
* One size does not fit all/generic approaches dont work
* Its not just hospitals!
* Investing in workforce improves the local economy (World Bank)
* Technology remains only a tool and not the answer
* Team work to manage multiple morbidities
* Pathways to practice are important and all the steps must be coordinated
* The diversity of rural communities means that there needs to be a level of local autonomy, allowing clinicians to grow their services to meet local needs
* Continuity of care, compassion and humanitarian values are still vitaly important (don’t forget to ask the patients, their families and their communities)
* No mandatory services/conscription
* Using other country’s professional robs from others in more need

**Finally we want to promote the next EURIPA Rural Forum**

**19th - 21st October, at Călimănești-Căciulata, in southern Romania**

John Wynn-Jones